MONTANA TRAUMA FACILITY ~~RESOURCE~~ DESIGNATION CRITERIA

Montana Department of Public Health and Human Services
EMS and Trauma Systems Section

Note: Occasional variances from these standards may occur.
These should be reviewed as part of the hospital's trauma performance improvement process.

The following table shows levels of trauma facility designation and their essential "E" or desirable "D" characteristics

TRAUMA FACILITY CRITERIA	LEVELS			
	Regional Trauma Center	**Area Trauma Hospital**	**Community Trauma Facility**	**Trauma Receiving Facility**
FACILITY ORGANIZATION				
Facility				
Demonstrated institutional commitment / resolution by the hospital Board of Directors and Medical Staff within the last three years to maintain the human and physical resources to optimize trauma patient care provided at the facility.	E	E	E	E
Participation in the statewide trauma system including participation in Regional Trauma Advisory Committee; support of regional and state performance improvement programs; and submission of data to the Montana State Trauma Registry.	E	E	E	E
Trauma Service				
A clinical service recognized in the medical staff structure that has the responsibility for the oversight of the care of the trauma patient. Specific delineation or credentialing of privileges for the medical staff on the Trauma Service must occur.	E	D		
Trauma Program				
~~Multidisciplinary program that coordinates trauma-related activities including performance/performance improvement for trauma patients, educational programs for providers of trauma care, injury prevention, and public education.~~ There is an identifiable trauma program that has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	E	E	E	E
Trauma Team				
A team of care providers to provide initial evaluation, resuscitation and treatment for all injured patients meeting trauma system triage criteria. The members of the team must be identified and have written roles and responsibilities.	E	E	E	E
The trauma team is organized and directed by a general surgeon with demonstrated competence in trauma care who assumes responsibility for coordination of overall care of the trauma patient.	E	E	~~E~~[1] D	
The trauma team is organized and directed by a physician with demonstrated competency in trauma care and is responsible for the overall provision of care for the trauma patient from resuscitation through discharge.			E	
The trauma team is organized and directed by a physician, physician assistant, or nurse practitioner with demonstrated				E

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competency in trauma care and is responsible for the overall provision of care for the trauma patient from resuscitation through discharge.				
~~Written trauma system triage criteria must be present and a method to activate the trauma team must exist.~~ There are clearly written criteria for trauma team activation that are continuously evaluated by the multidisciplinary trauma committee.	E	E	E	E
The general surgeon is expected to be present in the ED upon patient arrival for all patients meeting hospital specific criteria for the highest level of trauma team activation given sufficient advance notification or within 20 minutes of notification 80% of the time.	E			
Trauma response criteria for general surgeon activation will be specified. The general surgeon is expected to be present in the ED upon patient arrival for those meeting criteria if given sufficient advance notice or within 30 minutes of notification 80% of the time		E		
The Community Trauma Facility must have a trauma team plan for when the general surgeon is available and a second schema for when the general surgeon is not available. When available to respond, the general surgeon is expected to be present in the ED upon patient arrival for those meeting criteria if given sufficient advance notice or within 30 minutes of notification 80% of the time.			E	
Trauma Medical Director				
Board-certified or board eligible surgeon (usually general surgery) with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director ~~should have~~has the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, recommending trauma service privileges, development of ~~treatment protocols~~ clinical care guidelines, coordinating performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.	E			
Physician board-certified or board eligible in Surgery or Emergency Medicine with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director ~~should have~~has the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, recommending trauma service privileges, development of ~~treatment protocols~~ clinical care guidelines, coordinating performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.		E		
Physician board-certified or board eligible in a recognized specialty; with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director ~~should have~~has the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, development of ~~treatment protocols~~clinical care guidelines, coordinating performance improvement, correcting deficiencies in			E[9]	

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trauma care, and verification of continuing trauma education.				
Physician, nurse practitioner, or physician assistant with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director should have the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, development of ~~treatment protocols~~clinical care guidelines, coordinating performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.				E[9]
The trauma medical director must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related CME or maintain current verification in ATLS.	E[2]	E[2]	E[2]	E[2]
~~Completion of an ATLS course with preference for current verification~~.	~~E~~	~~E~~	~~E~~	~~D~~
Trauma Coordinator				
A full-time dedicated registered nurse working in concert with the trauma director, with responsibility for organization of services and systems necessary for a multidisciplinary approach to care for the injured. Activities include completion of the on-line trauma coordinator course, clinical oversight, with periodic rounding on admitted trauma patients, provision of clinical trauma education and prevention, performance improvement, provision of feedback to referring facility trauma programs, supervision of the trauma registry, ~~consultation/liaison~~ and involvement in ~~community~~local, regional and the state trauma system activities.	E			
A registered nurse working in concert with the trauma director, with responsibility for organization of services and systems necessary for a multidisciplinary approach to care for the injured. Activities include completion of the on-line trauma coordinator course, clinical care and oversight, provision of clinical trauma education and prevention, performance improvement, provision of feedback to referring facility trauma programs, trauma registry, utilization of the MT Trauma Treatment Manual, and involvement in ~~community~~ local, ~~and~~ regional and state trauma system activities. There must be dedicated hours for this position.		E	E	
A registered nurse or alternately a qualified allied health personnel working in concert with the trauma director, with responsibility for organization of services and systems necessary for a multidisciplinary approach to care for the injured. Activities include clinical care and oversight, provision of clinical trauma education and injury prevention, ~~quality/~~performance improvement, trauma registry, utilization of the MT Trauma Treatment Manual, and involvement in ~~community~~ local~~and~~ regional, and state trauma system activities. There must be dedicated hours for this position.				E
Trauma Registrar				
Designated trauma registrar working in concert with the trauma coordinator, with responsibility for data abstraction, entry into the	E			

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trauma registry and ability to produce a variety of reports routinely and upon request. There must be sufficient dedicated hours for this position to complete the trauma registry for each trauma patient within 60 days of discharge				
Identified trauma registrar or trauma coordinator with responsibility for data abstraction, entry into the trauma registry and ability to produce a variety of reports routinely and upon request. There must be sufficient dedicated hours for this position to .to complete the trauma registry for each trauma patient within 60 days of discharge		E	E	E
The trauma registrar must attend , or have previously attended, within 12 months of hire a national or state trauma registry course.	E	E	E	E
Trauma Committees				
~~*Trauma Program Performance*~~ *Multidisciplinary Trauma Committee* functions with a multidisciplinary committee which includes representation from ~~of~~ all trauma related services to assess and correct global trauma program process issues. This committee meets regularly, takes attendance, has minutes, and works to correct overall program deficiencies to optimize trauma patient care.	E	E	E	E
Trauma Peer Review functions with a multidisciplinary committee of medical disciplines (including the trauma coordinator) involved in caring for trauma patients to perform confidential, protected peer review for issues such as response times, appropriateness and timeliness of care, and evaluation of care priorities. This committee under the ~~aegis~~ auspices of performance improvement meets regularly, takes attendance, ~~has minutes, and documents how patient care problems will be avoided in the future.~~ and documents performance improvement evaluation and agreed upon action plans.	E	E	E	E
The trauma medical director ensures dissemination of information and findings from the trauma peer review meetings to the medical providers not attending the meeting.	E	E	E	E
Diversion Policy				
A written policy and procedure to divert patients to another designated trauma care service when the facility's resources are temporarily unavailable for optimal trauma patient care.	E	E	D	D
All trauma patients who are diverted to another trauma center, acute care hospital or specialty center must be subjected to performance improvement case review.	E	E	D	D
Prehospital Trauma Care				
The trauma program reviews pre-hospital protocols and policies related to care of the injured patient.	E	E	E	E
Trauma team activation criteria have been provided to EMS and are readily available to allow for appropriate and timely trauma team activation.	E	E	E	E
EMS has representation on the multidisciplinary trauma committee or documentation of involvement where perspective and issues are presented and addressed.	E	E	E	E
EMS is provided feedback through the trauma performance improvement program.	E	E	E	E

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Inter-Facility Transfer				
Inter-facility transfer guidelines and agreements consistent with the scope of the trauma service practice available at the facility.	E	E	E	E
Signed inter-facility transfer agreements in place for transfer of special population trauma patients to a higher level of care.	E	E	E	E
Burn Care – Organized				
In-house or transfer agreement with Burn Center	E	E	E	D
Acute Spinal Cord Management				
In-house or transfer agreement with Regional Trauma Center	E	E	E	D
Pediatrics				
In-house or transfer agreement with Regional Trauma Center or Pediatric Hospital	E	E	E	E
Feedback regarding trauma patient transfers shall be provided to the trauma program at the transferring hospital in a timely manner after patient discharge from the receiving hospital. The trauma coordinator at the transferring hospital is encouraged to contact the Regional Trauma Center/Area Trauma Hospital coordinators for verbal feedback.	E	E		
All trauma patients who are transferred during the acute hospitalization to another trauma center, acute care hospital or specialty center must be subjected to performance improvement case review.	E	E	E	E
Trauma System Participation				
There is active involvement by the hospital trauma program staff in state/regional trauma system planning, development and operation.	E	E	E	E
Disaster Preparedness				
~~There is a written disaster plan that is updated routinely~~ There is a written emergency operations plan that is updated and exercised routinely	E	E	E	E
Active hospital representation on the Local Emergency Planning Committee (LEPC)	E	E	E	E
~~The facility participates in community disaster drills~~. Routine participation in community disaster drills.	E	E	E	E
~~**FACILITY DEPARTMENTS / DIVISIONS / SECTIONS**~~				
~~***Surgery***~~	~~E~~	~~E~~	~~E~~	
~~***Neurosurgical Surgery***~~	~~E~~	~~D~~		
~~Neurosurgical Trauma Liaison~~	~~E~~	~~D~~		
~~***Orthopedic Surgery***~~	~~E~~	~~E~~	~~D~~	
~~Orthopedic Trauma Liaison~~	~~E~~	~~D~~	~~D~~	
~~***Emergency Medicine***~~	~~E~~	~~D~~	~~D~~	
~~Emergency Medicine Trauma Liaison~~	~~E~~	~~E~~	~~D~~	
~~***Anesthesia***~~	~~E~~	~~D~~	~~D~~	
CLINICAL CAPABILITIES				
~~***Published On-Call Schedule***~~	~~E~~[2]	~~E~~[2]	~~E~~[2]	~~D~~
~~General surgery~~	~~E~~	~~E~~	~~E~~	
~~Published back-up schedule~~	~~E~~	~~D~~		

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~~Dedicated to single hospital when on call~~	~~E~~	~~D~~		
~~Anesthesia~~	~~E~~	~~E~~	~~E~~	
~~Emergency Medicine~~	~~E~~	~~E~~	~~E~~[11]	~~E~~[11]
On-call and Promptly Available				
General / Trauma Surgeon	E[3]	E[4]	E[4]	
Published back-up schedule and dedicated to a single hospital when on call or performance improvement process in place to demonstrate prompt general surgeon availability.	E	D		
Process in place to assure the on-call general surgeon is notified and responds to the ED within the required time frame for trauma patient resuscitation. The trauma performance improvement process will monitor each surgeon's notification and response times.	E	E	E	
Anesthesia – MD or CRNA	E[5]	E[5]	E[5]	
The availability of Anesthesia and the absence of delays in airway control and operative anesthesia management must be identified and reviewed to determine reasons for delay, adverse outcomes and opportunities for improvement.	E	E	E	
Cardiac surgery	D			
Critical care medicine	E	D	D	
Hand surgery	E	D		
Microvascular/replant surgery	D			
Neurologic surgery	E	D		
Dedicated to one hospital or ~~backup call~~ performance improvement process in place to demonstrate prompt neurosurgeon availability	E	D		
Obstetric / Gynecologic surgery	E	D	D	
Ophthalmic surgery	E	D		
Oral / maxillofacial surgery	E	D		
Orthopaedic surgery	E	E	D	
Plastic surgery	E	D		
Pediatrics	E	D		
Radiology	E	E	D	
Thoracic surgery	E			
Urologic surgery	E	D		
Vascular surgery	E			
Response parameters for consultants addressing time-critical injuries (e.g. epidural hematoma, open fractures, hemodynamically unstable pelvic fractures, etc.) should be determined and monitored. Variances should be documented and reviewed regarding reason for delay, opportunities for improvement and corrective actions.	E	E	D	
CLINICAL QUALIFICATIONS				
General / Trauma Surgeon				
Full, unrestricted general surgery privileges	E	E	E	
Board-certified or board eligible	~~E~~[9]E[1]	~~E~~[9]E[1]	~~D~~[9]D[1]	
ATLS course completion	E[10]	E[10]	E[10]	
Trauma Education: 10 hours of trauma-related CME ~~annually~~ per	~~E~~[6]E[2]	E[6,7]E[2]	D[6,7]D[2]	

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year on average or demonstrate participation in an internal educational process by the trauma program or remain current in ATLS.				
Attendance of the general surgeons at a minimum of 50% of the trauma ~~multidisciplinary~~ peer review committee meetings.	E	E	~~D~~E	
~~Plan in place to notify transferring facilities that the surgeon is not available to the community~~			~~E~~	
Emergency Medicine				
Physicians are board-certified or board eligible	~~E~~[9]E[1]	~~E~~[9]E[1]	~~D~~[9] E[1]	
Emergency Department covered by medical providers qualified to care for patients with traumatic injuries who can initiate resuscitative measures.	E	E	E	~~D~~E
Trauma education for physicians, physician assistant, or nurse practitioner providing Emergency Department coverage: 10 hours of trauma-related CME ~~annually~~per year on average or demonstrate participation in an internal educational process by the trauma program or remain current in ATLS. or remain current in ATLS.	~~E~~[6]E[2]	~~E~~[6, 7] E[2]	~~E~~[6, 7] E[2]	~~D~~[6, 7] D[2]
ATLS course completion unless board certified in emergency medicine. CALS (Comprehensive Advanced Life Support) Provider certification (WITH completion of CALS Trauma Module) may substitute for ATLS Re-certification for Community & Trauma Receiving Facilities	E[10]	E[10]	E[10]	E[10]
Emergency Department trauma liaison	E	E	E	
The emergency department liaison must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related CME.	E	E	E	
Attendance of an emergency physician representative at a minimum of 50% ~~multidisciplinary~~ of the trauma peer review committee meetings	E	E	E	D
Anesthesia – MD or CRNA				
Board certified or board eligible	E[1]	E[1]		
Anesthesia trauma liaison	E	E	E	
Attendance of anesthesia representative at a minimum of 50% of the trauma peer review committee meetings	E	E	E	
Neurologic Surgery				
Board-certified or board-eligible	~~E~~[9]E[1]	~~D~~[9]		
ATLS course completion	D	D		
Trauma Education: 10 hours of trauma-related CME ~~annually.~~ Per year on average or demonstrate participation in an internal educational process by the trauma program or remain current in or teach ATLS.	~~E~~[6]E[2]	~~D~~[6]D[2.]		
Neurosurgical trauma liaison	E	D		
The neurosurgeon liaison must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related CME.	D	D		

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Attendance of a neurosurgery representative at a minimum of 50% multidisciplinary peer review committee meetings.	E	D		
Orthopaedic Surgery				
Board certified or board eligible	~~E~~[9]E[1]	~~E~~9E[1]		
ATLS course completion	D	D	D	
Trauma Education: 10 hours of trauma-related CME ~~annually.~~ Per year on average or demonstrate participation in an internal educational process by the trauma program or remain current in or teach ATLS.	~~E~~[6]D[2]	~~D~~[6].D[2]	~~D~~[6]D[2]	
Orthopaedic trauma liaison	E	E	D	
The orthopaedic surgeon liaison must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related CME..	E[2]	E[2]	D[2]	
Attendance of an orthopaedic surgery representative at a minimum of 50% ~~multidisciplinary~~ of the trauma peer review committee meetings.	E	~~D~~E	D	
Radiologist				
Board certified or board eligible	E[1]			
Radiologist trauma liaison	E	D		
Attendance of an radiologist representative at a minimum of 50% of the trauma peer review committee meetings.	E	D		
ICU Physician				
ICU physician trauma liaison	E	D		
Attendance of a ICU physician representative at a minimum of 50% of the trauma peer review committee meetings.	E	D		
FACILITIES / RESOURCES / CAPABILITIES				
Emergency Department				
Personnel:				
Designated physician director	E	E	~~E~~D	D
Emergency Department coverage by in-house emergency physician	E	E		
Emergency Department coverage by in-house physician, physician assistant, or nurse practitioner			D	
If the in-house emergency medical provider must be temporarily out of the department to cover in-house emergencies, there must be a PI process in place to assure that care of the trauma patient is not adversely affected	E	E		
Emergency Department coverage may be physician, physician assistant, or nurse practitioner on-call and promptly available			E[2]	E[2]

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There is a system in place to assure early notification of the on-call medical provider so they can be present in the ED at the time of trauma patient arrival. This is tracked in the trauma performance improvement process.			E	E
Emergency Department staffing shall ensure nursing coverage for immediate care of the trauma patient	E	E	E	D
Trauma nursing education: ~~8~~ 6 hours of trauma-related education annually, trauma-related skill competency or maintenance of TNCC/ATCN or equivalent.	E	~~D~~E	~~D~~E	~~D~~E
Nursing personnel to provide continual monitoring of the trauma patient from hospital arrival to disposition to ICU, OR, floor or transfer to another facility	E	E	E	E
***Equipment for resuscitation for patients of* ALL AGES**				
Airway control and ventilation equipment including laryngoscope and endotracheal tubes, bag-mask resuscitator and oxygen source	E	E	E	E
Rescue airway devices	E	E	E	E
Pulse oximetry	E	E	E	~~D~~E
Suction devices	E	E	E	E
~~Qualitative e~~End-tidal CO^2 ~~determination~~detector	E	E	E	D
~~Electrocardiograph, oscilloscope,~~ Cardiac monitor and defibrillator	E	E	E	~~D~~E
Internal paddles	E	E		
Waveform capnography	E	E	D	
~~CVP monitoring equipment~~	~~E~~	~~E~~	~~D~~	
Standard IV fluids and administration sets	E	E	E	E
Large bore intravenous catheters	E	E	E	E
Sterile surgical sets for:				
Airway control/cricothyrotomy	E	E	E	E
Thoracostomy (chest tube insertion)	E	E	E	E
~~Venous cutdown~~	~~E~~	~~E~~	~~D~~	
Central line insertion	E	E	D	
Thoracotomy	E	E		
Peritoneal lavage or ability to do FAST ultrasound exams	E	E	~~D~~E	
Arterial ~~Catheters~~pressure monitoring	E	D	D	
Ultrasound availability	~~D~~E	~~D~~E	D	
Drugs necessary for emergency care	E	E	E	E
Cervical ~~traction~~ stabilization ~~devices~~collars	E	E	~~D~~E	~~D~~E
Pelvic stabilization method	E	E	E	E
Pediatric equipment appropriately organized	E	E	E	E
Current pediatric length based resuscitation tape	E	E	E	E
Intraosseous Insertion Device	E	E	E	D
Thermal control equipment:				
Blood and fluids	E	E	~~D~~E	D
Patient	E	E	E	E
Resuscitation room	E	E	D	D
Rapid fluid infuser system	E	E	~~D~~E	E
Communication with EMS vehicles	E	E	E	E

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Operating Room				
~~***Personnel***~~				
Adequately staffed and available in a timely fashion 24 hours / day	E[8]	E[8]	D[8]	
Trauma performance improvement will monitor operating room availability and on-call surgical staff response times must be routinely monitored and any case which exceed the institutionally agreed upon response time must be reviewed for reasons for delay and opportunities for improvement.	E	E	D	
Age-specific Equipment				
Equipment for monitoring and resuscitative	E	E	E	
Cardiopulmonary bypass	D			
Operating microscope	D	D		
Thermal control equipment:				
Blood and fluids	E	E	E	
Patient	E	E	E	
Operating room	E	E	D	
X-ray capability~~, including c-arm image intensifier~~	E	E	E	
Endoscopes, bronchoscopes	E	E	D	
Craniotomy instruments	E	D		
Equipment for long bone and pelvic fixation	E	E	D	
Rapid fluid infuser system	E	E	~~D~~E	
Post-Anesthetic Recovery Room *(ICU is acceptable)*				
Registered nurses available 24 hours / day	E	E	D	
Age-specific Equipment				
Equipment for monitoring and resuscitation	E	E	E	
Intracranial pressure monitoring equipment	E			
Pulse oximetry	E	E	E	
~~Thermal control~~	~~E~~	~~E~~	~~E~~	
Thermal control equipment:				
Blood and fluids	E	E	E	
Patient	E	E	E	
Intensive ~~or Critical~~ Care Unit ~~for Injured Patients~~				
Registered nurses with ~~8~~ 6 hours trauma education annually	E	~~D~~E	D	
Designated surgical director or surgical co-director	E	E		
ICU service physician in-house 24 hours / day	D	D		
Trauma surgeon remains in charge of the multiple trauma patient in the ICU	E	E	D	
Age-specific Equipment				
Equipment for monitoring and resuscitation	E	E		
Intracranial pressure monitoring equipment	E	D		
Pulmonary artery monitoring equipment	E	E		
Thermal control equipment:				
Blood and fluids	E	E	E	
Patient	E	E	E	
Respiratory Therapy Services				
~~Available in-house 24 hours / day~~In-house respiratory therapist	E	D	~~D~~	
Respiratory therapist available in-house or on~~On~~-call 24 hours / day		E	~~E~~D	

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Radiological Services ~~(Available 24 hours / day)~~				
In-house radiology technologist	E	~~D~~E	~~D~~	
Radiology technologist ~~-~~available in-house or on-call 24 hours / day		~~E~~	E	D
Radiologists are promptly available for interpretation of radiographs, CT scans, performance of complex imaging studies and interventional procedures.	E	E		
Radiologists are promptly available for interpretation of radiogarphic studies			E	E
Radiologist diagnostic information is communicated in a written form in a timely manner.	E	E	E	E
Final radiology reports accurately reflect communications, including changes between preliminary and final interpretations.	E	E	E	E
Angiography	E	D		
~~Sonography~~Ultrasound	E	E	D	
Computed Tomography	E	E	D	
In-house CT ~~technician~~ technologist	~~D~~E	D		
CT technologist available in-house or on-call 24 hours / day		E	D	
Magnetic Resonance Imaging	~~D~~E	D		
MRI technologist in-house or on-call 24 hours / day	E			
Must routinely monitor on-call radiology, CT and MRI technologist institutionally agreed upon response times and review for reasons for delay and opportunities for improvement.	E	E	E	D
Clinical Laboratory Service ~~(Available 24 hours / day)~~				
In-house laboratory technician	E	D		
Laboratory technician available in-house or on-call 24 hours / day		E	E	D
Must routinely monitor on-call technician institutionally agreed upon response time and must be reviewed for reasons for delay and opportunities for improvement.		E	E	D
Standard analysis of blood, urine, and other body fluids, including micro-sampling when appropriate	E	E	E	D
Blood typing and cross-matching	E	E	E	
Coagulation Studies	E	E	E	D
~~Comprehensive blood bank or access to a community central blood bank and adequate storage facilities~~	~~E~~	~~E~~	~~E~~	
Massive Transfusion Policy (clinical and laboratory)	E	E	~~E~~	
The blood bank has an adequate supply of packed red blood cells, fresh frozen plasma, platelets, cryoprecipitate or coagulation factors to meet the needs of the injured patient.	E	E		
The blood bank has an adequate supply of packed red blood cells and fresh frozen plasma to meet the needs of the injured patient.			E	D
Process of care for rapid reversal of anticoagulation	E	E	E	D
Blood gases and pH determinations	E	E	E	
Microbiology	E	E	E	
Drug and alcohol screening	E	E	D	
~~Acute Hemodialysis~~				
~~In-house or transfer agreement with Regional Trauma Center~~	~~E~~	~~E~~	~~E~~	~~D~~

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~~***Burn Care – Organized***~~				
~~In-house or transfer agreement with Burn Center~~	~~E~~	~~E~~	~~E~~	~~D~~
~~***Acute Spinal Cord Management***~~				
~~In-house or transfer agreement with Regional Trauma Center~~	~~E~~	~~E~~	~~E~~	~~D~~
Rehabilitation Services				
~~Transfer agreement to an approved inpatient rehabilitation facility~~	~~E~~	~~D~~	~~D~~	
Physical Therapy	E	E	D	D
Occupational Therapy	E	D	D	
Speech Therapy	E	D	D	
Social Services	E	E	D	D
PERFORMANCE IMPROVEMENT				
The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	E	E	E	E
~~Performance improvement program for trauma patients.~~ There is a clearly defined performance improvement program for the trauma patient population.	E	E	E	E
There is a process to identify the trauma patient population for performance improvement review.	E	E	E	E
Active and timely p~~P~~articipation in the ~~state~~ State Trauma Registry	E	E	E	E
~~Audit of~~ A~~a~~ll trauma deaths are reviewed with analysis done to identify opportunities for improvement.	E	E	E	E
~~Medical staff~~There is a process where clinical care issues are discussed in confidential, protected ~~-~~trauma care peer review with analysis at regular intervals to meet the needs of the trauma program.	E	E	E	~~D~~E
There is a process where operational issues are discussed in the multidisciplinary trauma committee for analysis at regular intervals to meet the needs of the trauma program.	E	E	E	E
The results of issue analysis will define corrective action strategies or plans that are documented.	E	E	E	E
The results or effectiveness of the corrective action plans/strategies are documented.	E	E	E	E
~~Medical nursing audit~~	~~E~~	~~E~~	~~E~~	~~E~~
Review of prehospital trauma care is included in the trauma performance improvement program.	E	E	E	E
Programs that admit more than 10% of trauma patients to nonsurgical services should be subject to individual case review to determine rationale for admission onto a non-surgical service, adverse outcomes and opportunities for improvement.	E	E		
Neurotrauma care should be routinely evaluated as to compliance with the Brain Trauma Foundation Guidelines.	E	E		
All transfers of trauma patients to a higher level of care within the hospital must be routinely monitored and identified cases reviewed to determine rationale for transfer, adverse outcomes and opportunities for improvement.	E	E	D	
~~Annual trauma conference - multidisciplinary~~	~~E~~	~~E~~	~~D~~	~~D~~
The trauma program will participate in benchmarking with other	E	D		

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facilities of the same designation level to identify how the trauma center performs compared to others.				
CONTINUING EDUCATION / OUTREACH				
Clinical trauma~~Trauma~~ education provided by hospital for:				
Physicians, physician assistants & nurse practitioners	E	D	D	
Nurses	E	E	D	
Allied health personnel	E	E	D	
Prehospital personnel ~~provision / participation~~	E	E	D	
The trauma center will participate in a TEAM course every 3 years or when significant change in staff warrants additional training.			D	D
PREVENTION				
The trauma center participates in injury prevention	E	E	E	D
Designated injury prevention coordinator ~~– spokesperson for injury control~~	E	D		
Identified injury prevention spokesperson which could be the trauma coordinator or designee		E	E	D
~~Outreach activities~~	~~E~~	~~D~~	~~D~~	
Injury prevention priorities are based on local/state data	E	D	D	D
Collaboration with existing national, regional and state programs	E	D	D	D
Monitor progress / effect of prevention program	~~D~~E	D	D	D
There is a mechanism to identify trauma patients with alcohol and drug misuse issues	E	E		
The trauma center has the capability to provide intervention or referral for trauma patients identified with alcohol and drug misuse issues	E	E		
~~Information resources for public~~	~~E~~	~~D~~	~~D~~	~~D~~
~~Coordination and / or participation in community prevention activities~~	~~E~~	~~E~~	~~D~~	~~D~~
~~Collaboration with other institutions~~	~~D~~	~~D~~	~~D~~	~~D~~

~~1 The community trauma hospital must have a trauma team plan for when the general surgeon is available and a second schema for when the general surgeon is not available.~~

~~2 A system must be developed to assure early notification of the on-call physician, Physician Assistant, or Nurse Practitioner so that he/she can be present at the time of trauma patient arrival in the Emergency Department. The facility's trauma performance improvement process must track this through documentation of notification and response times. The Department, through site surveys, will monitor this performance category.~~

~~3 The general surgeon is expected to be present in the ED upon patient arrival in all patients meeting the hospital specific guidelines for defining a major resuscitation when given sufficient advance notification from the field OR within 20 minutes of notification. The Department, through site surveys, will monitor this performance category.~~

~~4 Each designated facility will develop processes to assure that the general surgeon on-call for trauma will be notified in a timely manner of an impending trauma patient arrival and that the surgeon will be present to direct the trauma team through the initial resuscitation. The general surgeon on-call must be able to respond promptly OR within 30 minutes of notification. The facility's trauma performance improvement process will monitor each surgeon's response times and document these times on the trauma flow sheet. The Department, through site surveys, will monitor this performance category.~~

~~5 Local criteria must be established for Anesthesiologists or CRNA to be rapidly available for airway emergencies and operative management. The availability of the Anesthesiologist or CRNA and the absence of delays in airway control and/or operative anesthesia management must be documented in the hospital performance/performance improvement process. The Department, through site surveys, will monitor this performance category.~~

~~6 Maintenance of current ATLS verification or course completion is recommended and may replace the trauma related continuing education requirement.~~

~~7 Each designated facility will develop performance improvement processes to assure the operating room is available and on-call operating room staff are notified and respond in a timely manner for emergent surgical procedures.~~

~~8 Alternate criteria for board certification is the physician must have completed an approved residency program, be licensed to practice medicine, be approved by the hospital credentialing committee, and have experience caring for trauma patients which must be followed in the quality / performance improvement program.~~

~~10 All physicians, physician assistants, and nurse practitioners providing emergency trauma care are expected to have completed an ATLS student course. Current ATLS verification or course completion is recommended for all physicians, physician assistants, and nurse practitioners who work in the emergency department and are boarded in a specialty other than emergency medicine.~~

~~11 Emergency Department coverage may be physician, Physician Assistant, or Nurse Practitioner on-call and promptly available.~~

1 Alternate criteria for board certification is the physician must have completed an approved residency program, be licensed to practice medicine, be approved by the hospital credentialing committee, and have experience caring for trauma patients which must be followed in the performance improvement program.

~~9~~2 ~~Trauma continuing education is required to be approved by a regulating authority.~~ Trauma continuing education can be obtained in a variety of ways such as attendance at attending facility trauma peer review meetings that provide education Regional Trauma Advisory Committee (RTAC) meetings and State Trauma Care Committee (STCC) meetings. External trauma-related education can ~~Over a three-year period, 1/3 of the continuing medical education to be should~~ be obtained outside of one's own institution and/or by educators from outside the institution.

10/2/2007